Vicarious Trauma: The Impact of Working with Survivors of Trauma

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Practitioners who work in the criminal justice services, both statutory and voluntary, have long known that a huge number of the people they come into contact with have long histories of challenging life circumstances. While in Ireland we have limited data regarding the breadth and depth of traumatic experiences in the lives of people who are incarcerated, we are aware that most emerge from situations of marginalisation, poverty, mental health and addiction[1], (Kennedy et al., 2005). There is growing recognition that early life experiences, particularly adverse childhood experiences, have a direct role in the development of later negative events and behaviours (Taylor et al., 2008: Fellitti et al 1998). The public often lacks empathy for those who commit crime (Schissel, 2016) as too can professionals (Kjelsberg et al., 2007). However, the client blameworthy perspective is being challenged by advances in research, particularly public health, neuroscience and developmental psychology. This new evidence indicates that people who have been exposed to chronic stress and trauma in childhood are not engaged in 'bad behaviour' but 'adaptive behaviour' (Lambert & Gill-Emerson, 2017). Adverse structural changes occur in the developing brain due to exposure to adverse childhood experiences (Teicher & Samson, 2013). This conference paper will discuss the impact on front line staff of working with vulnerable people and ways in which organisations can respond to improve outcomes for service users, staff and the whole organisation. In order to understand the impact on staff we must first understand the types of trauma presenting.

Psychological trauma can be understood as exposure to primary trauma (i.e. directly exposed to a traumatic event) and secondary trauma (indirect exposure to traumatic events from exposure to others stories). It is important to not assume that all clients present with primary trauma and that all staff are impacted by secondary trauma. However, to act as if there is a trauma history maximises the safety of the worker and client by reducing the likelihood of further re-traumatisation (SAMSHA, 2014). There are many variables at play in human services organisations. As workers we bring with us our own life experiences and some of us will have been exposed to our own personal trauma histories. Additionally workers can face primary trauma experiences through their work, such as exposure to threats and violence, finding a person deceased etc. (McGinley & Lambert, 2018). It is important to be cognisant of our own stories and how this may make us more vulnerable to hearing the stories of others.

[1] Oberstown Children's Detention Campus (2018). Key characteristics of young people in detention. https://www.oberstown.com/wp-content/uploads/2018/06/Key-Characteristics-2018.pdf

Trauma can be classified and includes developmental trauma, intergenerational trauma, and one off trauma events such as illness or accident. The last ten years has seen an increased interest in Adverse Childhood Experiences (ACEs) and their impact on later life outcomes. The original ACE study conducted by Fellitti et al. (1998) utilised a ten item scale recording a range of traumatic events in childhood such as abuse, neglect and household dysfunction (e.g. loss of a parent, exposure to addiction, mental health and domestic violence). This study had been replicated many times and the findings indicate that exposure to early life adversity increases the risk for poor physical and mental health and poor social functioning (Lambert & Gill-Emerson, 2017; Bethell et al., 2014), even in the absence of health risk behaviours (Fellitti et al., 1998). The original study revealed that exposure to adverse childhood experiences is common with almost 40% of the general population experiencing two ACEs. However this decreases to 12.5% for four or more ACEs. It has been argued that four ACEs are clinically significant and that each additional ACE has a dose response for increasing the likelihood of illness and dysfunction (SAMSHA, 2018). For example a score of 4 increases the risk for attempted suicide 23.2 times (WHO, 2014).

Is this then simply a case that having a bad childhood means you engage in bad behaviour? Not necessarily, and the research reveals that it is much more complicated than that. Research is emerging and on-going but it is argued that epigenetic changes occur in the presence of consistent toxic stress (Meaney, 2010). Advances in neuroscience have revealed that exposure to toxic stress or trauma in childhood impacts on the ways in which the developing brain hard wires with very serious consequences for later life functioning (Shonkoff et al., 2009; Danese et al., 2012). The adult brain is not fully formed until the 25th year of life and undergoes many changes throughout childhood and adolescence (Johnson, Blum & Giedd, 2009). Experiences of a warm responsive caregiver and exposure to a range of educational experiences facilitate healthy brain development (Gunner, 1998). However, exposure to toxic stress or developmental trauma can cause synaptic pruning or the death of neural connections at just the time when the brain should be forming and growing (Schore, 2001)[2]. Individuals exposed to high levels of stress have highly responsive fight or flight systems (Danese & McEwen, 2012). Arousal of the sympathetic nervous system has consequences for thinking and behaviour (Perry et al., 1995); individuals whose systems are set on flight or fight experience both their internal and external world as threatening (Janoff-Bullman, 1989). The behavioural manifestation of this stress response can range from aggression to withdrawal (Kisiel et al., 2014). Often these behaviours are viewed as challenging

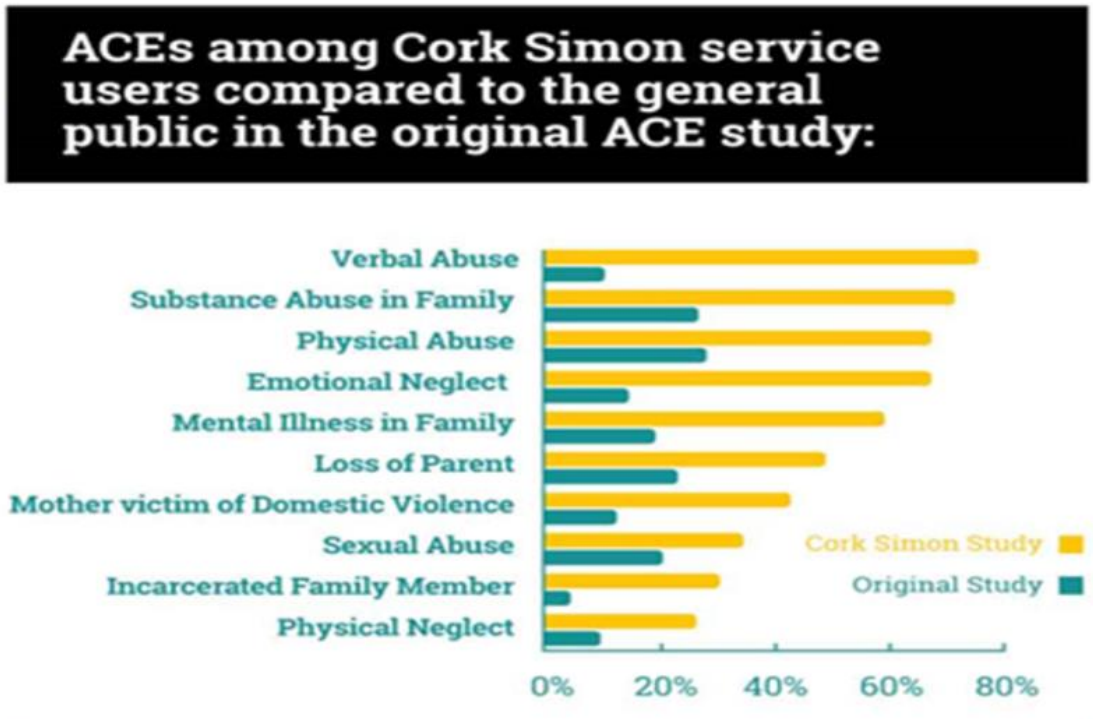
[2] https://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/

when in fact the impacted individual has little control over these automatic systems. The 'challenging' behaviours presenting may well have once been required for survival in childhood.

Research advancements have improved our understanding of the impact of trauma. In terms of understanding the implications of this for a criminal justice context one must consider the profile of those passing through the systems. Within the criminal justice system there are a disproportionately higher number of former care leavers, mental health sufferers, and people experiencing homelessness, people from impoverished and deprived backgrounds and those who are socially excluded. High levels of childhood trauma have been identified in all of these cohorts. There can be no dispute but that the most vulnerable and marginalised amongst our community are those who end up incarcerated. Exposure to childhood adversity with limited or no intervention leads directly to the adoption of high risk behaviours, social dysfunction and risk of early death (Fellitti et al., 1998; Lambert & Gill-Emerson, 2017)

An ACE study was conducted in a Cork based homelessness organisation. A collaboration between Applied Psychology, UCC, the HSE Adult Homeless Integrated Team and Cork Simon Community, the study collected ACE and other data from fifty service users. The results indicated very high levels of exposure to early childhood adversity and demonstrated the stark differences between the childhoods of those experiencing homelessness and those from the general public (See figure below: courtesy of Cork Simon Community).

The evidence suggests that many people transitioning through the criminal justice system have high levels of trauma and researchers would argue that there is a potential for trauma contagion (Gill-Emerson, 2015). Trauma contagion refers to the concept that working with trauma



survivors may increase the risk for vicarious trauma, secondary traumatic stress and burnout for some. The terms are at times used interchangeably in the literature. According to Pearlman & Mac Ian (1995) vicarious trauma occurs following long-term exposure to the stories of traumatised service users and may cause decreased motivation and empathy. An additional feature of this is a risk of a 'distorted world view' (McCann & Pearlman, 1990). The experiences of workers in front line services represent a small minority of the general population as a whole. However if a worker develops vicarious trauma they may perceive their world as more unsafe than the actual statistical risk. Staff may isolate themselves from others who do not work in front line services as they no longer hold similar views of risk, danger and trauma and may tend to gravitate more towards others who share similar occupational experiences. Secondary trauma stress differs to vicarious trauma in that it does not change a person's world view. It has instead been described as a syndrome among staff working with trauma survivors that mimics post-traumatic stress disorder (Figley, 1995). This can be as a result of exposure to service users' trauma stories or it can occur suddenly as a direct result of exposure to a stressful incident such as violence or finding a service user dead (Baird & Kracen, 2006; McGinley & Lambert, 2018). It must be noted that not all staff in front line services are impacted by secondary or vicarious trauma and many report feeling satisfaction with their ability to offer care and develop a connection with service users (Jacobson, 2006). Burnout occurs when the demands outweigh the resources and results in physical and emotional fatigue that may also result in disengagement from work and the depersonalisation of service users. This is an adaptive response where the stress becomes so overwhelming that, in order to continue to function, the worker needs to disengage from empathising with service users in order to protect one's own mental health; this usually occurs over a period of time and may be an unconscious process for the worker. Other symptoms of burnout may include feelings of helplessness and despair, insomnia, health risk behaviours (e.g. over eating, misuse of substances), difficulties within personal relationships etc. (Baker et al., 2007; McGinley & Lambert, 2018). It can become systemic in that a whole organisation can be impacted. Vicarious and secondary trauma have been described as 'occupational hazards' for those who work in front line services, therefore the organisations have a "practical and ethical responsibility to address this risk" (Bell, Kulkarni, & Dalton, 2003, p. 465). There are a number of ways that an organisation can respond to their staff needs; regular and effective supervision that is separate and distinct from line management, the focus is on the impact of the work. Reflective practice in supervision is an effective way to reduce the impact of the work on staff (O'Sullivan, 2018). A work environment that demonstrates good practice in relation to self-care is vital.

Addressing the trauma needs of both service users and staff results in a range of benefits for the organisation such as decreased incidents, increased morale and staff retention to name but a few. Many organisations that provide services to vulnerable and marginalised groups now recognise the importance of adopting a trauma informed work environment. A trauma informed environment is one that understands the impact of trauma on both service users and staff and makes changes to policies, procedures and practices (SAMSHA, 2014). A trauma informed service does not necessarily treat trauma using clinical interventions. It does however recognise the levels of trauma within its organisation and responds to these (Lambert & Gill-Emerson, 2017). Workspaces have become increasingly focused on output, risk management and paperwork. Taking the focus away from the people, both staff and service users, increases the risk for all involved including the organisation itself. Workplaces need to invest in understanding trauma and its impact in order to maximise the safety of all within that organisation.

References:

1. Kennedy et al., (2005). Mental Illness in Irish Prisoners. http://www.drugsandalcohol.ie/6393/1/4338_Kennedy_Mental_illness_in_Irish_prisoners.pdf
2. Oberstown Children's Detention Campus (2018). Key characteristics of young people in detention. https://www.oberstown.com/wp-content/uploads/2018/06/Key-Characteristics-2018.pdf
3. Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. & De Bortoli, L. (2008). *The Cost of Child Abuse in Australia*. Available from: URL: http://www.stopchildabusenow.com.au/pdf/Access%20Economic%20Report_Exec%20Summary_FINAL.pdf
4. Kjelsberg, E., Skoglund, T. H., & Rustad, A. B. (2007). Attitudes towards prisoners, as reported by prison inmates, prison employees and college students. *BMC Public Health*, *7*(1), 71.
5. Lambert, S., & Gill-Emerson, G. (2017). Moving towards trauma-informed care. A model of research and practice www.drugandalcohol.ie
6. Teicher M., & Samson J. (2013). Childhood maltreatment and psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *Am J Psychiatry. 170(10)*:1114- 33.
7. Substance Abuse and Mental Health Services Administration (SAMHSA). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. http://store.samhsa.gov
8. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The

Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

9. Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014). Adverse childhood experiences: assessing the impact on health and school engagement and the mitigating role of resilience. *Health Affairs*, *33*(12), 2106-2115.
10. Substance Abuse and Mental Health Services Administration (SAMHSA), (2018). Adverse Childhood Experiences. https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences
11. World Health Organisation (2014). http://www.euro.who.int/ data/assets/pdf file/0010/267283/Survey-on-the-prevalence-of-adverse-childhood-experiences-among-young-people-in-the-Russian-Federation-Eng.pdf
12. Johnson, S. B., Blum, R. W., & Giedd, J. N. (2009). Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health*, *45*(3), 216-221.
13. Danese A, McEwen BS (2012). Adverse childhood experiences, allostasis, allostatic load, and age-related disease. Physiol Behav.;106:29-39.
14. Shonkoff JP, Boyce WT, McEwen BS (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. JAMA.;301:2252-9.
15. Meaney MJ. (2010). Epigenetics and the biological definition of gene x environment interactions. Child Dev.;81:41-79.
16. Johnson, S. B., Blum, R. W., & Giedd, J. N. (2009). Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health*, *45*(3), 216-221.
17. Music, G. (2016). *Nurturing natures: Attachment and children's emotional, sociocultural and brain development*. Routledge.
18. Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant mental health journal*, *22*(1-2), 201-269.
19. Gunnar, M. R. (1998). Quality of early care and buffering of neuroendocrine stress reactions: Potential effects on the developing human brain. *Preventive medicine*, *27*(2), 208-211.
20. Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits". *Infant mental health journal*, *16*(4), 271-291.
21. Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social cognition*, *7*(2), 113-136.
22. Kisiel, C. L., Fehrenbach, T., Torgersen, E., Stolbach, B., McClelland, G., Griffin, G., & Burkman, K. (2014). Constellations of interpersonal trauma and symptoms in child welfare:

Implications for a developmental trauma framework. *Journal of Family Violence*, *29*(1), 1-14.

23. Wilson, F. E., Hennessy, E., Dooley, B., Kelly, B. D., & Ryan, D. A. (2013). Trauma and PTSD rates in an Irish psychiatric population: A comparison of native and immigrant samples. *Disaster health*, *1*(2), 74-83.
24. Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, *26*(6), 558.
25. Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Social Services, 84*(4), 463-470.
26. Baker, L. M., O'Brien, K. M., & Salahuddin, N. M. (2007). Are shelter workers burned out?: An examination of stress, social support, and coping. *Journal of Family Violence*, *22*(6), 465-474.
27. Jacobson, J. M. (2006). Compassion fatigue, compassion satisfaction, and burnout: Reactions among employee assistance professionals providing workplace crisis intervention and disaster management services. *Journal of Workplace Behavioral Health, 21*(3-4), 133-152.
28. Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Baltimore: The Sidran Press.
29. Gill-Emerson, G. (2015). The Trauma Contagion. *Eisteach, 15*(1), 8-11.
30. McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, *3*(1), 131-149.
31. Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, *19*(2), 181-188.
32. McGinley, M. & Lambert, S. (2018). Homelessness: A Trauma Contagion? In press
33. O'Sullivan, N (2018): Creating space to think and feel in child protection social work; a psychodynamic intervention, Journal of Social Work Practice, DOI: 10.1080/02650533.2018.1460589